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IN THE

Supreme Court of the United States

DAVID KING, ET AL.,

Petitioners,

v.

SYLVIA BURWELL, SECRETARY OF HEALTH AND HUMAN SERVICES, ET AL.,

Respondents.

On Writ of Certiorari to the United States Court of Appeals for the Fourth Circuit

BRIEF FOR *AMICUS CURIAE* NATIONAL ALLIANCE OF STATE HEALTH CO-OPS IN SUPPORT OF RESPONDENTS

WOODY N. PETERSON
Counsel of Record
JENNIFER D. HACKETT
PETER W. MORGAN
ALLISON M. VISSICHELLI
DICKSTEIN SHAPIRO LLP
1825 Eye Street, N.W.
Washington, D.C. 20006
(202) 420-2200
petersonw@dicksteinshapiro.com
Counsel for Amicus Curiae

WILSON-EPES PRINTING CO., INC. – (202) 789-0096 – WASHINGTON, D. C. 20001

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INTEREST OF *AMICUS CURIAE*[1]

Amicus National Alliance of State Health CO-OPs ("NASHCO") is a non-profit trade association. Its membership consists of the non-profit health insurance cooperatives formed as a result of Congress' direction in the Patient Protection and Affordable Care Act ("Affordable Care Act," "ACA," or "Act"), Pub. L. No. 111-148, 124 Stat. 119[2] that the Secretary of Health and Human Services ("HHS") establish the Consumer Operated and Oriented Plan ("CO-OP") program, pursuant to section 1322 of the Act.

NASHCO's twenty-two health insurance CO-OP members make it possible for individuals and businesses to purchase high quality, low cost, member-governed health insurance in twenty-three States: *Arizona* (Meritus Health Partners); *Colorado* (Colorado HealthOp); *Connecticut* (HealthyCT); *Illinois* (Land of Lincoln Health); *Kentucky* (Kentucky Health Cooperative); *Louisiana* (Louisiana Health Cooperative, Inc.); *Maine* and *New Hampshire* (Maine Community Health Options); *Maryland* (Evergreen Health Cooperative Inc.); *Massachusetts* and *New Hampshire* (Minuteman Health, Inc.); *Michigan* (Michigan Consumers Healthcare CO-OP); *Montana* and *Idaho* (Montana Health Cooperative); *Nevada* (Nevada Health Cooperative); *New Jersey* (Health

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[1] *Amicus* certifies that both parties have given blanket consent to the filing of *amicus curiae* briefs in support of either party. *Amicus* also certifies that no counsel for any party authored this brief in whole or in part, no party or party's counsel made a monetary contribution to fund its preparation or submission, and no person other than *Amicus* or its counsel made such a monetary contribution.

[2] Amended by the Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, 124 Stat. 1029.

Republic Insurance of New Jersey); *New Mexico* (New Mexico Health Connections); *New York* (Health Republic Insurance of New York); *Ohio* (InHealth Mutual); *Oregon* (Health Republic Insurance Company and Oregon's Health CO-OP); *South Carolina* (Consumers' Choice Health Insurance Company); *Tennessee* (Community Health Alliance Mutual Insurance Company); *Utah* (Arches Mutual Insurance Company); and *Wisconsin* (Common Ground Healthcare Cooperative).

Amicus and its members have a vital stake in this case. The viability of many of NASHCO's member CO-OPs could be threatened if, as Petitioners seek, tax credits for those insured by a CO-OP plan offered on an HHS-created Exchange are eliminated.

The government's merits brief catalogues many reasons why Petitioners' reading fails in light of the Act's text, structure, design, and legislative record, and the absurd and disastrous consequences that would result. NASHCO submits that the Act's CO-OP program provisions further confirm that conclusion. Petitioners' argument ignores the unique role CO-OPs play in the ACA statutory scheme and does violence to the text, structure, and purpose of the ACA's CO-OP program provisions. It also fails to confront the singular harms that reversal will cause ACA CO-OPs, the individuals and businesses that depend on them, and competition in the health care insurance marketplace.

SUMMARY OF ARGUMENT

The CO-OP program is an important component of the Affordable Care Act. CO-OPs offer a private, non-profit, member-governed alternative to for-profit health insurance companies. Congress created and funded the CO-OP program to increase health care

provider and insurance plan consumer choices, as well as competition among insurers. The ACA contemplated that every State would have at least one CO-OP offering qualified health plans on an Exchange in each State and the District of Columbia. In the four years since the Affordable Care Act CO-OP program was established, CO-OPs already have achieved many of the goals Congress set for them.

Under the ACA's implementing regulations, CO-OP plans must be offered on an "Exchange," regardless of whether the Exchange was established by a State, or by HHS. The CO-OP program provisions in the Affordable Care Act apply nationwide. Nothing in the ACA or its regulations differentiates in any way between a CO-OP established in a State with an HHS-created Exchange and a CO-OP established in a State with a State-created Exchange. Such a differentiation would have created a discriminatory distinction between CO-OPs and between individuals based solely on the State in which they happened to reside.

Petitioners nonetheless assert that, for purposes of making federal income tax credits available to individuals who purchase insurance on an Exchange, the Affordable Care Act requires an HHS-created Exchange to be treated differently than a State-created one. Petitioners' interpretation—which rests on a phrase in two subclauses elsewhere in the ACA—cannot be squared with the provisions in the Act that established CO-OPs, with the HHS regulations that implement the CO-OP program, or with the statutory context, structure, history, and purpose of those provisions.

If accepted, Petitioners' argument would mean the loss of federal tax credits for millions of Americans,

thwart Congress's express intent to have a CO-OP in every State, reduce competition and consumer choice in the majority of States, and could sound the death knell for the entire ACA CO-OP program. Many CO-OPs may not survive unless their members can use federal tax credits to reduce the cost of their insurance premiums. The vigorous debate surrounding the CO-OP program that led to its inclusion in the ACA, and the support the program garnered from some of the staunchest opponents of the Act as a whole, confirms that Congress did not statutorily mandate a CO-OP program and appropriate billions of dollars to run it, only to crater it in a lone phrase in other provisions.

Properly read, the Affordable Care Act makes tax credits available to consumers who purchase CO-OP health care plan insurance no matter where they live or the CO-OPs operate, and regardless of what entity happened to create the Exchange on which the consumers bought the insurance.

ARGUMENT

I. CONGRESS CREATED AND FUNDED THE ACA CO-OP HEALTH CARE INSURANCE PROGRAM TO PROMOTE COMPETITION AMONG INSURERS AND AFFORDABLE CHOICE FOR CONSUMERS IN EVERY STATE

A. Health Care Cooperatives: Background

Cooperatives are not new. They have a long history in this country and exist in many sectors of the economy, such as housing, child care, agriculture, credit unions, and health care. Julia James, *The CO-OP Health Insurance Program*, Health Affairs Health Pol'y Brief, Jan. 23, 2014, at 1. Cooperatives generally are private member-owned organizations created for the express purpose of providing an alternative to more traditionally-run, for-profit organizations. Health care cooperatives, for example, differ from traditional private insurers in that the co-ops are nonprofit entities governed by their members and are focused on coordinating care and coverage for the beneficiaries of their plans. *See* 42 U.S.C. § 18042(b)(2)(C)(i)(I), (c)(1)(A); Bradford H. Gray, *Consumer Operated and Oriented Plans (CO-OPs): An Interim Assessment of Their Prospects*, Timely Analysis Health Pol'y Issues, Aug. 2011, at 3.

Even before the ACA CO-OP program became law, at least twenty-eight States already had some form of State-regulated health care cooperative, some of which were and remain very substantial and successful. For example, HealthPartners in Minnesota has 1.5 million members, and Group Health Cooperative in Washington, 700,000. Terry Gardiner et al., *Realizing Health Reform's Potential: Innovative*

Strategies to Help Affordable Consumer Operated and Oriented Plans (CO-OPs) Compete in New Insurance Marketplaces, Commonwealth Fund Issue Brief, Apr. 2012, at 2. Both of these cooperatives have their own physicians and health care facilities, and rank among the highest-performing health plans in the country in terms of the value and quality of care they offer. *Id.* The drafters of the ACA looked to these successful models in crafting the statutory provisions for a program that would incentivize the creation and promote the financial stability of health care cooperatives in every State. Gray, *supra*, at 3.

B. The Origins of the ACA CO-OP Program

Congress enacted the Affordable Care Act to "increase the number of Americans covered by health insurance and decrease the cost of health care." *National Fed'n of Indep. Bus. v. Sebelius*, 132 S. Ct. 2566, 2580 (2012); *see also* 42 U.S.C. § 18091(2)(C) (stating that the Act will have the effect of adding millions of new customers to the health insurance market and increasing the number and share of Americans who are insured). Congress recognized that, among other things, individuals and small businesses lacked sufficient affordable alternatives to the existing private insurance market, and that such alternatives were necessary to achieve the goal of near-universal health care coverage for all Americans. Gray, *supra*, at 2; Nancy Lopez, *The Consumer Operated and Oriented Plan (CO-OP) Program*, Health Reform GPS (June 22, 2011), http://healthreformgps.org/resources/the-consumer-operated-and-oriented-plan-co-op-program. An initial proposed alternative was a national government-run health plan—the "public option"—that would operate in a similar manner to Medicare or Medicaid and provided

a lower-cost alternative to private health insurance. Gray, *supra*, at 2.

It became clear, however, that including the public option in the bill would lead to its defeat in the Senate. The CO-OP program then emerged as a compromise, with Senator Conrad (D-ND) introducing it as a private, State-level system, in which each CO-OP would negotiate separately with providers. *Id.* Senator Conrad, Senator Grassley (R-IA) (who opposed the ACA but saw value in the CO-OP program, especially in rural areas), and others drafted the ACA CO-OP provisions. Robert Costa, *Grassley on Obamacare: 'The Straw that Broke the Camel's Back,'* Nat'l Rev. Online (Aug.19, 2009, 4:15 PM), http://www.nationalreview.com/corner/185871/grassley-obamacare-straw-broke-camels-back/robert-costa; Gray, *supra*, at 2.[3]

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[3] According to this contemporaneous account in National Review Online, when Senator Grassley was asked about "non-profit cooperatives, which have gained steam this week as a possible point of compromise between Republicans and the Obama administration," Senator Grassley replied that "[I'm] all for them — if done correctly":

> "I don't think a lot of senators have an understanding of the 150-year history of cooperatives in the United States," [Senator Grassley] said. "They're basic to the economy of the Midwest. Those of us who have an understanding of them know that they're consumer-run, with all the benefits going to consumer members. There is no federal control over them. There is no government control over them any more than the control states have over other health-care issues."

Costa, *supra*. In Senator Grassley's view, health care cooperatives were "an opportunity to enhance health-care competition—just as cooperatives do in other areas of the economy." *Id.*

The goals of the CO-OP program included injecting competition into health insurance markets across the country (in most States at least sixty-five percent of the health insurance market is dominated by three or fewer for-profit insurance companies)[4] and providing consumers with a private, local insurance option that would use any profits to lower premiums, increase benefits, and otherwise increase the quality of health care and coverage. Lopez, *supra*. Even some of the legislators who objected to the Act as a whole recognized that CO-OPs could provide much-needed choice, coverage options, and competition in the health insurance arena, especially in States with many rural communities. Gray, *supra*, at 2; James, *supra*, at 1.

C. The ACA CO-OP Program: Statutory and Regulatory Provisions

In many ways, ACA CO-OPs are similar to traditional cooperatives in that both types have consumer-governed boards elected by members. *See* 42 U.S.C. § 18042(c)(3). ACA CO-OPs are not, however, owned by their members, but instead are organized as nonprofit member corporations under State law. *See* 42 U.S.C. § 18042(c)(1)(A). A CO-OP is obligated to use any profits it earns "to lower premiums, to improve benefits, or for other programs intended to improve the quality of health care delivered to its members." *Id.* § 18042(c)(4). Substantially all of the activities of the CO-OP must consist of issuing CO-OP qualified health plans in the individual and small group markets; substantially all of the CO-OP policies or contracts for health insurance

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[4] James C. Robinson, *Consolidation and the Transformation of Competition in Health Insurance, Health Affairs* 23(6) Health Aff. 11, 15 (2004).

likewise must be such plans offered in those markets. *Id.* § 18042(c)(1)(B); 45 C.F.R.§ 156.515(c)(1).

Congress appropriated billions of dollars to fund CO-OP program loans or grants to a qualifying CO-OP.[5] The Regulations promulgated by the Secretary of HHS provide that in order to receive an ACA loan, the CO-OP must offer insurance plans on State "Exchange[s]." 45 C.F.R. §156.515(c). The CO-OPs have relied on the Regulation that defines an "Exchange" as one that meets the applicable statutory and regulatory criteria, "*regardless of whether the Exchange is established and operated by a State (including a regional Exchange or subsidiary Exchange) or by HHS.*" 45 C.F.R. § 155.20 (emphasis added).

The Act requires the Secretary to "ensure that there is sufficient funding to establish at least 1 qualified nonprofit health insurance insurer [i.e., a CO-OP] in each State." 42 U.S.C. § 18042(b)(2)(A)(iii). In determining whether to authorize grants or loans to a CO-OP; the Secretary must, among other things, give priority to applicants that offer qualified CO-OP health plans on a statewide (rather than local) basis. *Id.* § 18042(b)(2)(A).

The ACA contains additional provisions to ensure that, in States in which no one initially applies to form a CO-OP, the Secretary of HHS will be able to offer additional grants, either to induce potential applicants

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[5] 42 U.S.C. § 18042(g), *amended by* Department of Defense and Full-Year Continuing Appropriations Act, Pub. L. No. 112-10, § 1857, 125 Stat. 38; Consolidated Appropriations Act, 2012, Pub. L. No. 112-74, § 524, 125 Stat. 786; American Taxpayer Relief Act of 2012, Pub. L. No. 112-240, § 644, 126 Stat. 2313.

to form CO-OPs, or incentivize CO-OPs in neighboring States to agree to cover a State with no CO-OP of its own. *Id.* § 18042(b)(2)(B). None of these CO-OP provisions or Regulations, or any other ACA provision or Regulation, distinguishes between CO-OPs in States with State-created Exchanges and those in States with HHS-created Exchanges. If the definition of "Exchange" in the ACA Regulation had excluded HHS-created Exchanges, such that enrollees in CO-OP plans offered in those Exchanges would not have been eligible for federal tax credits, no CO-OPs would have been established in those States in the first place.

II. ACA CO-OPS NATIONWIDE ALREADY HAVE TAKEN SIGNIFICANT STRIDES TOWARDS THE CO-OP PROGRAM'S GOALS

ACA CO-OPs have considerably altered the health insurance landscape. They have moved the industry closer to reaching the Act's goals of bringing more choice, wider coverage, and increased competition to the health insurance marketplace, especially for lower-income individuals who now can use federal tax credits to afford a CO-OP plan offered through an Exchange.

A. Wider Coverage and Greater Enrollment

HHS issued the first start-up loans in 2012 to eight CO-OPs in nine States. *The Center for Consumer Information & Insurance Oversight: Loan Program Helps Support Customer-Driven Non-Profit Health Insurers*, Centers for Medicare & Medicaid Services (Dec. 16, 2014), http://www.cms.gov/CCIIO/Resources/Grants/new-loan-program.html. As of January 2015, twenty-three States had at least one CO-OP. By the

end of 2014, CO-OPs had enrolled over 500,000 members, with many CO-OPs already exceeding their original enrollment goals. For example, Maine already had 40,880 enrollees in its CO-OP, who represented 83 percent of the State's overall Exchange enrollment, and 264 percent of the CO-OP's original first year projection. Similarly, Wisconsin had 24,739 enrollees, nearly 250 percent of its enrollment target for year one. And, Kentucky Health Cooperative had seventy-five percent of the total enrollment on Kentucky's Exchange.

Maintaining and increasing enrollment in CO-OPs, as Maine, Wisconsin, Kentucky, and many others have done, are crucial to reaching the goals of the ACA CO-OP program. The ACA explicitly seeks to increase competition in the stagnant private health insurance market in order to decrease health insurance premiums. Greater competition and lower prices will only occur if individuals continue to enroll in CO-OPs, and increased enrollment depends upon the continuation of federal tax credits to help offset health insurance premiums.

B. Lower Premiums

A recent survey found that in the twenty-three States that have CO-OPs, overall health insurance premiums are approximately eight to nine percent lower than in States without them.[6] Moreover, in the CO-OP States, CO-OPs offer thirty-seven percent of the lowest-priced plans and, even where they are not

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[6] *Health Insurance CO-OPs: Examining Obamacare's $2 Billion Loan Gamble: J. Hearing Before the Subcomm. on Energy Policy, Health Care and Entitlements of the H. Comm. on Oversight and Government Reform*, 113th Cong. 36–37 (2014) (written statement of NASHCO Executive Director Jan VanRiper).

the lowest cost option, CO-OP plans still are the most likely of all insurers to be within ten percent of the lowest-priced plan.[7] Another study[8] examined premium changes made by the lowest cost bronze and two lowest cost silver health insurance plans in a major city in each State.[9] The study noted that the second-lowest cost silver plan in each State is of particular interest because it serves as a benchmark that helps determine how much of a federal tax credit an eligible individual can receive. *Id.* The study showed that from 2014 to 2015, monthly premium rates for the second-lowest cost silver plan in CO-OP States had fallen by 1.9 percent, but had risen by 1.5 percent in non-CO-OP States.[10] The same study further showed that the 2014 monthly premiums for a forty-year-old non-smoker with the second lowest cost

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[7] *Health Insurance Purchasing Cooperatives and Alliances: State and Federal Roles*, Nat'l Conf. St. Legislatures (Jan. 2015), http://www.ncsl.org/research/health/purchasing-coops-and-alliances-for-health.aspx.

[8] Cynthia Cox et al., *Analysis of 2015 Premium Changes in the Affordable Care Act's Health Insurance Marketplaces*, Kaiser Family Found. Issue Brief, Sept. 2014 (updated Jan. 6, 2015), *available at* http://kff.org/health-reform/issue-brief/analysis-of-2015-premium-changes-in-the-affordable-care-acts-health-insurance-marketplaces. The study originally was published in 2014 and examined premium changes in sixteen major cities in fifteen States and the District of Columbia. The study was updated in 2015 to include a major city in each State and account for the most recent premium data.

[9] The ACA defines plans by the levels of coverage they offer (from "bronze" to "platinum"). *See* 42 U.S.C. § 18022(d).

[10] Those percentages represent the calculated average of the percent change in the silver plans attributed to a major city in each CO-OP State and non-CO-OP State, respectively. Premiums are based on a forty-year old non-smoker earning $30,000 per year. *Id.*

silver plan were 9.5 percent lower in CO-OP States than those in non-CO-OP States, a monthly premium differential that increased to 12 percent in 2015.

C. Increased Competition and Improved Patient Care

The emergence of ACA CO-OPs already has had the intended effect of changing the traditional health insurance market. For example, in response to the entry of such CO-OPs into the market, large for-profit insurers have lowered their prices to compete more effectively with CO-OPs, whose plans generally are priced below those of the major health insurance companies. Cox et al., *supra*, at 6; Section II.B., *supra*.

In addition, the dominant carriers have changed their traditional customer practices in response to CO-OP competition. For example, the leading for-profit companies are taking steps to decrease the wait time for their customer service health insurance help lines, advertising their insurance plans more clearly and simply, and otherwise attempting to be more responsive to consumers. Rick Cohen, *Nonprofit Health Co-ops: Designed to Compete for the Public Good*, Nonprofit Q. (Oct. 24, 2014, 10:19PM), https://nonprofitquarterly.org/policysocial-context/25050-nonprofit-health-co-ops-designed-to-compete-for-the-public-good.html. These major players expect that these measures will allow them to be more competitive with the CO-OP programs, which are based on a customer service model. *Id.*

III. THE AFFORDABLE CARE ACT MAKES FEDERAL TAX CREDITS AVAILABLE TO CONSUMERS WHO PURCHASE CO-OP HEALTH CARE INSURANCE THROUGH ANY EXCHANGE

The continued growth and success of CO-OPs depend on many factors. One of the most important is that all individuals in any State who choose to enroll in any CO-OP health insurance plan on any Exchange remain eligible for the Affordable Care Act federal tax credits. That is so because individuals who cannot afford to pay health insurance plan premiums without those tax credits comprise the majority of enrollees in CO-OP programs.

Petitioners base their attack on the nationwide availability of tax credits on one phrase contained in two subclauses of the Act.[11] That phrase sets out the formula for calculating the federal tax credits available to low-income individuals who purchase insurance on Exchanges.[12] The thrust of Petitioners' argument is that individuals who purchase insurance offered by CO-OPs in States that created Exchanges are eligible for such tax credits, but those who do so on Exchanges in States in which HHS created the Exchanges are not. That is, the availability of a

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[11] The phrase, "established by the State under [Section 18031]" appears in 26 U.S.C. § 36B(b)(2)(A), (c)(2)(A)(i).

[12] These tax credits are available to individuals who have incomes between 100 percent and 400 percent of the federal poverty level and who purchase insurance policies through an Exchange. 26 U.S.C. § 36B. Additional support, in the form of cost-sharing reductions to offset such expenses as co-pays and deductibles, is available for individuals whose incomes are between 100 percent and 250 percent of the federal poverty level. 42 U.S.C. § 18071.

federal tax credit for purchasing CO-OP plan insurance provided by a statute designed to offer affordable CO-OP plan coverage for "[*a*]*ll* Americans" (Tit. I, 124 Stat. 130 (emphasis added)) turns on the random fact of the *State* in which the purchaser happens to live.[13]

This reading of the statute is inconsistent with the text, structure, and purpose of the Act's CO-OP provisions. A nationwide CO-OP program was a fundamental part of the Affordable Care Act and enjoyed support even among those opposed to the Act as a whole. Unless CO-OP enrollees in all States can take advantage of the tax credits the Act affords, however, the program likely will fail. Without the tax credits, individuals would have less incentive, and need more money, to purchase insurance on an HHS-created Exchange. Moreover, given that the CO-OPs are tied to, and must offer their plans on, the Exchanges, if the tax credits were eliminated on Exchanges operated by HHS, CO-OPs in those States would be hard pressed to attract sufficient enrollment or comply with the ACA's requirement that substantially all CO-OP policies or contracts for health insurance must be qualified health plans offered in the individual and small group markets.

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[13] That would mean, for example, that a resident of Kentucky, who bought her health insurance plan from the Kentucky Health Cooperative through the State-created Kentucky Exchange, would keep her tax credits, but a resident who lived in Tennessee just across the Kentucky border, who bought his health insurance plan from the Community Health Alliance CO-OP through the HHS-created Tennessee Exchange, would lose his.

ACA's CO-OP provisions contemplate that every State ultimately will have at least one CO-OP.[14] At this point, twenty-three States do. Sixteen States, and the District of Columbia, have State-created Exchanges; thirty-four States have HHS-created Exchanges. If Petitioners' interpretation were correct, enrollees in CO-OP health insurance plans in thirteen of the twenty-three States that have CO-OPs would be ineligible for federal tax credits and related cost-savings support for their insurance premiums and expenses. That would almost necessarily mean that CO-OPs might soon exist only in ten States, instead of nationwide as the ACA envisions. If the major insurance companies faced no CO-OP competition in the other forty States or the District of Columbia, those companies could more easily concentrate on eliminating CO-OP competition in the remaining ten States. Such a subversion would "frustrat[e] . . . the very purposes" (*Sullivan v. Hudson*, 490 U.S. 877, 890 (1989)) of the Affordable Care Act's CO-OP program.

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[14] The ACA's definition of "State" includes the District of Columbia. 42 U.S.C. 1804(d).

CONCLUSION

Congress created, and allocated billions of dollars to fund, the Affordable Care Act CO-OP program to promote competition, choice, and improved health care for millions of Americans. Petitioners' argument depends on the premise that, having done so, Congress simultaneously guaranteed that the CO-OP program would be doomed to failure, the billions of allocated dollars would be wasted, consumers would be offered fewer choices, and competition would be decreased. Nothing in the "text, structure, history, and purpose" (*Maracich v. Spears*, 133 S. Ct. 2191, 2209 (2013)) of the Affordable Care Act CO-OP program supports such an irrational proposition.

The court of appeals should be affirmed.

Respectfully submitted,

WOODY N. PETERSON
Counsel of Record
JENNIFER D. HACKETT
PETER W. MORGAN
ALLISON M. VISSICHELLI
DICKSTEIN SHAPIRO LLP
1825 Eye Street, N.W.
Washington, D.C. 20006
(202) 420-2200
petersonw@dicksteinshapiro.com

Counsel for Amicus Curiae

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